pensing. It is to be hoped, however, that most members of both professions will welcome the new contract as a means of achieving a more rational distribution of pharmacies and ensuring a more comprehensive pharmaceutical service for all our patients, both rural and urban.

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1 National Health Service, England and Wales. *National Health Service (General Medical and Pharmaceutical Services) Amendment (No 2) Regulations 1987*. London: HMSO, 1987. (Statutory Instrument No 401.)
2 Department of Health and Social Security. *Health notice HC(FP)(87)2*. London: HMSO, 1987.

LMSSA: a back door entry into medicine?

SIR,—I was dismayed to read Mr Richard Wakeford's article (4 April, p 890), with its many inaccuracies and innuendos. The Society of Apothecaries examines candidates by authority of the Medical Act 1886 passed by parliament and not by virtue of a charter granted by King James I. This authority is the same as that for every other examining body.

Most of our examiners are consultants from teaching hospitals, who are also examiners for the MB examination. It is generally agreed that the standard of the examination is the same as that of the MB, and a close marking system is adopted so that although a marginal failure in any one section of the examination may be compensated for by extra marks in another section, a severe fail cannot be compensated for. The examiners are all external as far as the candidates are concerned, which ensures an independent assessment, unbiased by any previous knowledge of the candidate's performance during his or her student years. This system is adopted in all postgraduate examinations and is considered to be fairer to the candidate.

Mr Wakeford referred to 10 candidates who failed the Cambridge MB in December 1982. Altogether 13 Cambridge students entered for the LMSSA in 1983, all of whom had been approved by the dean of the medical school. Six completed the LMSSA at the first attempt, four completed it after more than one attempt, and three who failed the LMSSA subsequently passed the Cambridge MB. It is unreasonable to conclude that the society's examination is a "second rate qualification" on the basis of these figures.

The regulations ensure that candidates must pass all sections of the examination within two years and do not allow more than four attempts at any one section. In practice, however, it is unusual for candidates to complete the examination if more than two attempts are required to pass any one part. Overseas candidates are accepted only after graduating from medical schools approved by the General Medical Council and are required to have passed the Professional and Linguistic Association Board examination or been exempted from it.

Mr Wakeford refers to some universities that allow students only two attempts at the final examination. It is accepted that the selection of medical students ensures that only those of the highest intellectual ability may begin the course, and it is surely a great waste of public money if such students are denied the chance of qualifying after a long period of study. Above all, regular inspection of all bodies by the General Medical Council ensures the maintenance of high standards, and the Society of Apothecaries' examinations committee has always been ready to adapt to the council's suggestions.

The Society of Apothecaries has provided a diploma of a high standard since 1815, and we intend to maintain the service that we have hitherto provided for the profession and the public. Criticism of our examination is particularly resented when it comes from a medically unqualified and uninformed source who has never attended one of the society's examinations.

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Points

Perforation of nasal septum due to button battery lodging in nose

Mr M DAVENPORT (Children's Hospital, Sheffield S10 2TH) writes: Dr P Fernando's report of an alkaline button battery lodged in the nasal cavity (21 March, p 742) may cause misunderstanding about the management of the more common problem of batteries being swallowed. If the battery has passed beyond the oesophagus and is progressing through the gastrointestinal tract it is safest to await its passage.[1] The mechanism of perforation in the case described by Dr Fernando seems somewhat speculative. A battery's alkaline contents would leak only if its metal casing had disintegrated—surely an improbable event after only 24 hours in the nasal cavity. It has been suggested that a rise in pH occurs at the anode side because of the current produced by an undischarged cell and that it is this that causes local tissue necrosis, rather than the battery's contents.

1 David JJ, Ferguson AP. Management of children who have swallowed button batteries. *Arch Dis Child* 1986;**61**:321-2.

Dr D W SKINNER (Queen's Medical Centre, Nottingham NG7 2UH) writes: I should like to emphasise the concern about tissue necrosis and other long term consequences of button batteries as foreign bodies not only in the nose, as described by Dr P Fernado (21 March, p 742), but also in the ear. Any delay in the removal of button batteries may have very severe consequences. Recently, I reported on a 12 year old child with a button battery in the nose, who suffered extensive destruction of the inferior turbinate and adjacent septum, followed by a persistent local atrophic rhinitis, and will probably develop intranasal adhesions as a consequence. A case of a 5 year old child with a button battery in the external auditory canal has also been described, in which complete destruction of the tympanic membrane and ossicular chain occurred, with subsequent pronounced conductive hearing loss and great difficulties in reconstructing the middle ear structures.[1]

1 Skinner DW, Chui P. The hazards of "button-sized" batteries as foreign bodies in the nose and ear. *J Laryngol Otol* 1986;**100**:1315-8.

Identity cards for patients infected with HIV?

Dr GIUSEPPE ENRICO BIGNARDI (Pathology Department, Stepping Hill Hospital, Stockport SK2 7JE) writes: Dr N West (21 March, p 772) pointed out the consequences of breaches of confidentiality about patients with the acquired immune deficiency syndrome (AIDS). The dispatch of pathological specimens is unfortunately the best way to spread information on the identity of AIDS patients. According to DHSS guidelines, all specimens sent to a laboratory for whatever test must be accompanied by a form indicating knowledge or suspicion of HIV infection and a senior laboratory staff member must be informed in advance. This is unjustified. The risk of AIDS to health service staff is minimal and certainly lower than that posed by specimens positive for hepatitis B surface antigen.[1,2] While specimens are rightly tagged with a label indicating risk of infection, there is no reason for the card to carry other than a general label: possibly only one kind of label—"Risk of viral infection"—should be used for both hepatitis and HIV specimens with no need for any further indication. When samples are sent for HIV antibody testing the identity of the patient could be protected by assigning the sample a number rather than a name, as in genitourinary medicine clinics.

1 McCray E. Occupational risk of the acquired immunodeficiency syndrome among health care workers. *N Engl J Med* 1986;**314**:1127-32.
2 Geberding JL, Hopewell PC, Kaminsky LS, Sande MA. Transmission of hepatitis B without transmission of AIDS by accidental needlestick. *N Engl J Med* 1985;**312**:56.

Future of the pathologist in an era of technological change and cost containment

Dr J K JOHNSON (Dumfries and Galloway Royal Infirmary, Dumfries DG1 4AP) writes: I am concerned that greater emphasis on patient care in chemical pathology, as suggested by Drs M H Labib and L R Ranganath (7 March, p 642), may lead to neglect of the pathological role of the specialty. Advertisements for service registrar posts in chemical pathology are now attracting very high calibre applicants. Though it is not a requirement, the competition ensures that most of those who are appointed have either a scientific qualification as well as their medical qualification or a higher medical qualification with proved aptitude for laboratory work. These are the doctors who are most likely to becom chemical pathologists. The potential, in laboratory medicine, for an applicant with the MRCP but no scientific background is questionable.

Overuse of monitoring of blood concentrations of antiepileptic drugs

Dr E M R CRITCHLEY (Department of Neurology, Royal Preston Hospital, Preston, Lancashire PR2 4HT) writes: As Dr D W Chadwick suggests (21 March, p 723), concentration on drug monitoring may delay the search for the most suitable anticonvulsant for a particular patient. If an anticonvulsant does not reduce the number of fits when it is introduced it is unlikely to be successful if used in a higher dosage. If a patient's epilepsy becomes uncontrollable the possibility of an underlying lesion or of new trigger factors should be the doctor's first consideration. One man who was admitted to hospital repeatedly had his drug dosage increased on each admission. He was, in fact, an active homosexual who would have a fit whenever he got into trouble. Another patient, who weighed less than 44·5 kg and had miliary tuberculosis and meningitis, had a focal fit. He was given phenytoin but the serum concentration was monitored and the dosage increased to 400 mg with no account being taken of hepatic induction, which affected the blood concentrations of the antituberculous drugs that he was receiving.

Amenorrhoea

Dr G LIVINGSTON (Academic Department of Psychiatry, Royal Free Hospital, London NW3) writes: Dr S Franks mentions that the most common cause of secondary amenorrhoea, other than pregnancy, is weight loss (28 March, p 815) and that "the distinction between these patients and those with anorexia nervosa is not clear cut." As anorexia nervosa may be defined as "the mental symptoms of fear of fatness and distortion of body size, the behavioural signs of self starvation and weight loss and the pathophysiological state marked by amenorrhoea,"[1] many of these women may have anorexia nervosa. Anorexia nervosa is a positive diagnosis made clinically, which would be missed on this algorithm. It does not require endocrine investigations. In patients with amenorrhoea and weight loss the first investigation should be a history and identification of abnormal attitudes to eating. This would allow diagnosis and early treatment of anorexia nervosa, thus decreasing mortality and morbidity and saving the expense of unnecessary investigations.

1 Folstein MF, Wakeling A, DeSouza V. Analogue scale measurement of the symptoms of patients suffering from anorexia nervosa. In: Vigersky RA, ed. *Anorexia nervosa*. New York: Raven Press, 1977.